State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to:

California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

PLEASE NOTE: Effective January 1, 2004, new law governing enrollment of providers in the Medi-Cal program resulted in a process for the Department of Health Services (Department) to more thoroughly review applicants applying to participate in the Medi-Cal program and established a new provisional provider status. In addition, it resulted in revisions to the provider enrollment application forms.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned. Due to the volume of applications received, program staff are unable to reply to a request for the status of an application in process. Therefore, please allow for the 180 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Information about the completion of enrollment forms is located on the Medi-Cal Web site at **www.medi-cal.ca.gov**.

It is your responsibility to report to the Department any modifications to information previously submitted within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHS 6209, revised 7/04) form. However, if you are reporting a change of ownership of 50 percent or more, or a change of business address, you must complete a new application package.

Enrollment forms are available at **www.medi-cal.ca.gov** or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at **www.medi-cal.ca.gov** and click the "Provider Enrollment" link. If you have any questions, please submit your inquiry in writing to the above address

Provider Enrollment Branch
Payment Systems Division

Enclosures

(Revised 10/04)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL PROVIDER GROUP APPLICATION

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) and a Medi-Cal Provider Agreement (DHS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

Enrollment action requested (check one). Enter the date you are completing the application.

"New provider group"—the provider group is not currently enrolled with the Medi-Cal program and would like to have a Medi-Cal provider number issued.

For any of the following changes checked, please provide a current Medi-Cal Provider number.

"Change of business address"—the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

"Additional business address"—the applicant is currently enrolled in the Medi-Cal program and requesting a Medi-Cal provider number for an additional business location. Please enter the existing provider group number. New rendering providers at the additional business address must submit a separate Medi-Cal application (appropriate to their provider type), disclosure statement and provider agreement. (See Title 22, CCR, Section 51000.31(b).)

"Change of ownership"—there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

"Sale of assets (50 percent or more)"—fifty (50) percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

"New Taxpayer ID number"—a new Taxpayer Identification Number (TIN) is issued by the IRS.

"Cumulative change of 50 percent or more in ownership or control"—there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

"Add new rendering provider(s) for all locations enrolled for this provider group"—new rendering providers are enrolled pursuant to Title 22, CCR, Section 51000.31. The Medi-Cal provider numbers for all locations must be included with this request. Only locations for which this provider group is enrolled can be included.

"Continued enrollment"—the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current Medi-Cal provider number(s).

Check the box labeled "I intend to use my current..." if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51(b).

"Type of entity"—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

1. "Legal provider group name"—the legal business name listed with the Internal Revenue Service (IRS).
2. If this is a Fictitious Business Name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit to the application. Physician provider groups are to submit a legible copy of the Fictitious Business Name Permit issued by the Medical Board of California.
3. "Provider group telephone number"—the primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service phone, or answering machine shall not be used as the primary business telephone.
4. "Provider group business address"—the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable. Check box a. if this address is a licensed hospital/health facility. Check box b. if all services are provided at this address. Check box c. if you are requesting an exception pursuant to Welfare and Institutions (W&I) Code, Section 14043.15(b)(2). Attach a list of qualifying addresses.

5. "Pay-to address"—the address to which payment will be mailed. The pay-to address should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. "Mailing address" the address at which the applicant or provider wishes to receive general Medi-Cal correspondence. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the provider group or provider group applicant; or enter social security number (see Privacy Statement on page 4). Attach a legible copy of the IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
8. Enter the Medicare billing number.
9. Enter the Seller's Permit number issued by the State Board of Equalization. Attach a legible copy of the Seller's Permit.
10. Indicate the type of provider group (e.g. Audiologists, Certified Nurse Midwives, Chiropractors, Occupational Therapists, Optometrists, Orthotists, Orthotists and Prosthetists, Nurse Anesthetists, Nurse Practitioners, Physicians, Physical Therapists, Podiatrists, Prosthetists, Psychologists, Respiratory Therapists, Speech Therapists).
11. If this is a physician provider group, list the specialty(ies).
12. Enter the Clinical Laboratory Improvement Amendment (CLIA) Certificate number. Attach a legible copy of the CLIA Certificate.
13. Enter the State Laboratory License/Registration number. If this does not apply to you, enter "N/A." Attach a legible copy of the license/registration.
14. Enter any local business license or permit numbers for any city or county or city and county where you conduct your business and attach copies to the application. If this does not apply to you, enter N/A and provide an explanation.
15. List the name, license number, social security number, and date of birth of all ***new*** rendering providers in the provider group. Attach additional sheets, if necessary. An individual application, disclosure statement, and provider agreement are required for each new rendering provider in the provider group. The provider agreement is not required for physicians applying for enrollment as a rendering provider in a provider group. Provision of the social security number is optional (see Privacy Statement on page 4).
16. If you are providing services in a licensed hospital or clinic (facility), please complete this certification.
17. "Printed name of provider"—print the last, first, and middle name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to the California Department of Health Services for enrollment or continued enrollment as a provider in the Medi-Cal program.
18. Check (✓) the gender of the individual named in number 17.
19. Enter the driver's license or state-issued identification card number and state of issuance of the individual named in number 17. Attach a legible copy to the application. The driver's license or state-issued identification number shall be issued within the 50 United States or the District of Columbia.
20. Enter the date of birth of the individual named in number 17.
21. Enter the social security number of the individual named in number 17. Provision of the social security number is optional (see Privacy Statement on page 4).
22. An original signature of the individual named in number 17 is required. Also provide the title of the person signing the application. Include the city, state, and the date where and when the application was signed.
23. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.

✓ Remember to attach a legible copy of the following, if applicable:

- ❒ TIN verification
- ❒ Seller's Permit
- ❒ Fictitious Business Name Statement or Fictitious Name Permit
- ❒ Signed Medi-Cal Disclosure Statement (DHS 6207)
- ❒ Signed Medi-Cal Provider Agreement (DHS 6208)
- ❒ Complete application package for each rendering provider being added to the provider group
- ❒ Applicable certifications
- ❒ Driver's license or state-issued identification card of individual signing the application
- ❒ CLIA Certificate
- ❒ State Laboratory License/Registration

MEDI-CAL PROVIDER GROUP APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: California Department of Health Services
  Provider Enrollment Branch
  MS 4704
  P.O. Box 997413
  Sacramento, CA 95899-7413
  (916) 323-1945

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Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply)

Date

❒ New provider group

For any of the following actions, include current Medi-Cal provider number: _____

❒ Change of business address
❒ Additional business address
❒ Change of ownership
❒ Sale of assets (50 percent or more)
❒ New Taxpayer ID number
❒ Cumulative change of 50 percent or more in ownership or control
❒ Add new rendering provider(s) for all locations enrolled for this provider group
Specify group provider number(s): _____

❒ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)

❒ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51(b).

Type of entity (check one)

❒ Sole proprietor
❒ Partnership
❒ Government
❒ Corporation: Corporate number: _____ State incorporated: _____
❒ Limited liability company: Corporate number: _____ State incorporated: _____
❒ Nonprofit Type of nonprofit: _____
❒ Other: _____

1. Legal provider group name (as listed with the IRS)

2. Is this a fictitious business name? ❒ Yes ❒ No	If yes, list the Fictitious Business Name Statement/Permit number	Effective date	3. Provider group telephone number ( )
	(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)		

4. Provider group business address (number, street)	City	County	State	Nine-digit ZIP code

a. ❒ This address is a licensed hospital/health facility
b. ❒ All group services are provided at this location.
c. ❒ I am requesting an exception pursuant to W&I Code, Section 14043.15(b)(2). Attach a list of all qualifying addresses.

5. Pay-to address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number)	City	State	Nine-digit ZIP code

7. Taxpayer Identification Number (TIN) or social security number (Attach a legible copy of the IRS form.)	8. Medicare billing number	9. Seller's Permit number (attach a legible copy)

10. Type of provider group	11. If physician(s), list specialty(ies)

12. Clinical Laboratory Improvement Amendment (CLIA) Certificate number (attach a legible copy)	13. State Laboratory License/Registration number (attach a legible copy)	14. Any local business license/permit numbers (attach a legible copy)

15. List all ***new*** providers rendering in the provider group. (Use additional sheets if necessary. Attach complete application package for each provider.)

Name	License Number	Social Security Number	Date of Birth

16. SELF CERTIFICATION AND STATEMENT OF INTENT TO EMPLOY A SEPARATE BILLING METHOD FOR HOSPITAL/CLINIC BASED PROVIDER GROUPS. (TO BE COMPLETED ONLY IF THE PRACTICE LOCATION IS A LICENSED FACILITY.)

The undersigned hospital/clinic and provider group agree to the following requirements for the issuance of a Medi-Cal provider number to the hospital/clinic based group. It is agreed and understood by _____ and
(Provider group name)

_____
(Hospital/clinic name)

that there shall be no duplicate billing for inpatient services rendered to Medi-Cal beneficiaries. All billing for inpatient services provided by the group to Medi-Cal beneficiaries shall be billed using the provider group number. To ensure the money paid to the group is not included in the cost settlement process, we recommend that the hospital/clinic set up a separate nonreimbursable cost center to account for all clinic-related payments. Additionally, the hospital/clinic should keep track of overhead support costs related to the reimbursable costs. At year-end the costs related to the guarantee to group clinical billings should be easily identifiable by our audits staff on your cost report. If it appears impossible/impractical for you to set up a separate cost center, then the direct cost related to the group's clinical activities at a minimum should be eliminated from the trial balance cost via an A-8 adjustment on your cost report. This method of billing will become effective for services performed on or after _____ We declare under penalty of perjury
(Date)

under the laws of the State of California that the foregoing information is true and correct to the best of our knowledge.

Hospital/clinic name			
Address (number, street)	City	State	ZIP code
Print name of authorized hospital/clinic representative	Authorized hospital/clinic representative signature		Date
Print provider group name	Print name of authorized provider group representative		
Authorized provider group representative signature			Date

Information About Individual Signing This Application

17. Printed name of provider (last) (first) (middle)		18. Gender ❒ Male ❒ Female
19. Driver's license or state-issued ID number and state of issuance (attach a legible copy)	20. Date of birth	21. Social security number (***Optional***—see Privacy Statement below.) ___ ___ ___ – ___ ___ – ___ ___ ___ ___

22. **I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.**

Signature of provider	Title

Executed at: _____, _____ on _____
(City) (State) (Date)

23. Notary Public—Please see instructions under number 23 for who must notarize.

Privacy Statement
(Civil Code, Section 1798 et seq.)

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code, Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, (916) 323-1945.